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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A135 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

03980

Reg. Dist. No. 106

3978

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Fenwick</i>		LENGTH OF STAY (in this place) <i>35 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Fenwick</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <i>Adelle</i>		(Middle)		(Last) <i>Brooks</i>		(Month) (Day) (Year) <i>April 19 1957</i>	
<b>5. SEX</b> <i>F</i>	<b>6. COLOR OR RACE</b> <i>Negro</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>married</i>	<b>8. DATE OF BIRTH</b> <i>Feb 18, 1888</i>		<b>9. AGE last birthday</b> <i>69</i> yrs.		<b>10. IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Own Home</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Marshall Hall, MD</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.</i>	
<b>13. FATHER'S NAME</b> <i>William Ford</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Olivia Chandler</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>None</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Raymond Brooks Bryans Road MD</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>170x IMMEDIATE CAUSE (A)</b> <i>Carcinoma Left Breast</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>1 1/2 yrs</i>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>None</i>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>1957</i> , to <i>April 19, 1957</i> , that I last saw the deceased alive on <i>April 16, 1957</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>Frank G. Busin</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Indian Head MD</i>		<b>DATE SIGNED</b> <i>4-19-57</i>	
<b>23. (BURIAL) CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b> <i>4-23-57</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Macdonia Baptist Church</i>		<b>LOCATION</b> (City, town, or county) (State) <i>Bryans Road MD</i>	
<b>24. REC'D BY REGISTRAR</b> <i>APR 23 1957</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Odey Price</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Barnes &amp; Matthews</i>		<b>ADDRESS</b> <i>614-48 St. Louis</i>	

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex  
3. Age

4. Date of death

5. Place of death

BUREAU V. F.

APR 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: At Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3979

03981  
105

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MD

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Waldorf	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louise Middle Ernestine Last Chapman		4. DATE OF DEATH Month April Day 1 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1932
9. AGE (In years last birthday) 27 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Chapman		14. MOTHER'S MAIDEN NAME Erma A. Yates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-38-4072	
17. INFORMANT INIZ CHAPMAN		Address WALDORE, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage into Pleura 810X DUE TO Crushed Chest Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Instantaneous	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTENSAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto hit by train	
20c. TIME OF INJURY Month, Day, Year 10 Hour 4-1 1957		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Waldorf Charles Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. J. Edelen		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. Edelen, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-1-'57	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-57	
22c. NAME OF CEMETERY OR CREMATORY St Peter's Cem.		22d. LOCATION (City, town, or county) (State) WALDORE Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		ADDRESS WALDORE, Md.	
24a. REC'D BY REGISTRAR DATE 4/8/57		24b. REGISTRAR'S SIGNATURE M. L. Monroe	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03982

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>N.Y.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL LA PLATA</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RURAL RT. 301 LA PLATA.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Skaneateles N.Y.</b>			
				d. STREET ADDRESS <b>69X-3</b>			
3. NAME OF DECEASED (Type or print) First <b>LEON</b> Middle <b>W</b> Last <b>CLARKE</b>				4. DATE OF DEATH Month <b>4</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-10-33</b>	
9. AGE (In years last birthday) <b>23</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Thomas E. Clarke</b>				14. MOTHER'S MAIDEN NAME <b>Adeline Dinty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>				16. SOCIAL SECURITY NUMBER <b>123 60971</b>			
17. INFORMANT <b>Thomas E. Clarke</b>				Address <b>Skaneateles, N.Y.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CRUSHED CHEST</b> <b>825X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>BROKEN NECK</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Auto Accident</b> INTERVAL BETWEEN ONSET AND DEATH <b>4-14-57</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Chas.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>E. J. EDELEN</b>				DATE SIGNED <b>4-14-57</b>			
EXAMINER'S NAME (Type) <b>E. J. EDELEN M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>April 17, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Georgia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>4/17/57</b>		24b. REGISTRAR'S SIGNATURE <b>Julius J. Haney</b>	



BUREAU V. B.

APR 22 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03983

106

Reg. Dist. No.

3981

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andover Hill</u> c. LENGTH OF STAY IN <u>72</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Chas</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andover Hill</u> d. STREET ADDRESS <u>1 #14 1st St</u> e. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1957</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Leslie</u> First <u>GARRETT</u> Middle <u>FAIRFAX</u> Last				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>22</u> Year <u>1957</u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2-13-05</u>	
<b>9. AGE</b> (In years last birthday) <u>52</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Police</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Govt.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>VA.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>Daniel G. Fairfax</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Tommy Pettit</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b> <u>216 303861</u>				<b>17. INFORMANT</b> Address <u>Mrs Viola Fairfax Indian Head, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>420.1</u> <b>DUE TO</b> <u>Coronary Occlusion</u>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> (b) <u>  </u> <b>DUE TO</b> (c) <u>  </u> </div> <div style="width: 15%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>4-23-57</u> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u>			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>F. J. EDELIN</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>4-23-57</u>			
<b>EXAMINER'S NAME (Type)</b> <u>F. J. EDELIN</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>4-26-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Pohick Cem.</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Pohick, VA.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hunt Funeral Home</u> ADDRESS <u>Waldorf, Me.</u>				<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Day Process</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

APR 29 1957

BUREAU V. S.

APR 29 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05121

Reg. Dist. No.

107

3982

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NANJERMOY</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CHARLES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NANJERMOY</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KATIE</b> Middle <b>MAY</b> Last <b>FRANKLIN</b>		4. DATE OF DEATH Month <b>4</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5-21-99</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>5</b> Min. <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>MILARD SANDY</b>	
14. MOTHER'S MAIDEN NAME <b>CHARLOTTE SHANNON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT Address <b>BEULAH APPERSON Potomac Heights, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertension</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b> <b>inter.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>444X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank A. Susan M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank A. Susan M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-3-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>NANJERMOY Baptist Cem.</b>
		22d. LOCATION (City, town, or county) (State) <b>NANJERMOY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home</b>		ADDRESS <b>WALDORE, MD.</b>	24. REC'D BY REGISTRAR <b>MAY 8 1957</b>
		24b. REGISTRAR'S SIGNATURE <b>John Thompson</b>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BURIAL V. S.

MAY 8 1997

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03984

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

160

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Popes Creek</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Popes Creek</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Janie</b>		First		Middle <b>K.</b>		Last <b>Fulk</b>		4. DATE OF DEATH Month <b>4</b> Day <b>30</b> Year <b>19 57</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-4-'57</b>		9. AGE (In years last birthday) yrs. <b>1</b> Months <b>25</b> Days <b>25</b>		IF UNDER 1 YEAR Hours <b>25</b> Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Wilber G. Fulk</b>		14. MOTHER'S MAIDEN NAME <b>Etta Mae Sanders</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Wilber G. Fulk Popes Creek, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> 921.0 DUE TO Aspiration of gastric content Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4-30-'57</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Baby apparently vomited and aspirated fluid</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Chicamuxen, Md.</b>		(County)		(State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>5-1-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chicamuxen ME Cem.</b>		22d. LOCATION (City, town, or county) <b>Chicamuxen, Md.</b>		(State)		23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Edelen, M.D.</b>		24a. REC'D BY REGISTRAR <b>MAY 3 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Julia Pasco</b>	
25. FUNERAL HOME <b>The Hunt Funeral Home</b>		25b. ADDRESS <b>Waldorf, Md.</b>		25c. DATE <b>MAY 3 1957</b>		25d. REGISTRAR'S SIGNATURE <b>Julia Pasco</b>		25e. DATE <b>MAY 3 1957</b>		25f. REGISTRAR'S SIGNATURE <b>Julia Pasco</b>		25g. DATE <b>MAY 3 1957</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

MAY 3 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3984 CERTIFICATE OF DEATH

03985  
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Tobacco</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Tobacco</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>S.</u> Last <u>GRAY</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hom.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Scott</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Robert Gray Port Tobacco Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS</u> <u>170X</u> DUE TO (b) <u>ADENOCARCINOMA OF LEFT BREAST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>E NODAL METASTASES</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS.</u> <u>2 1/2 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY a. H. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 23</u> , 19 <u>53</u> , to <u>April 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 5</u> , 19 <u>57</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Parra Jarboe</u>				ADDRESS (Street, city or town, state) <u>La Plata, Md</u>		DATE SIGNED <u>4-6-57</u>	
PHYSICIAN'S NAME (Type) <u>J. PARRA JARBOE, M.D.</u>				<u>LA PLATA MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>4/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elmhurst</u>		22d. LOCATION (City, town, or county) (State) <u>Thomson, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Gray</u>				ADDRESS <u>La Plata, Md</u>		24a. REC'D BY REGISTRAR DATE <u>4/8/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Julia J. P. Gray</u>			



BUREAU V. S.

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RECEIVED

03986

## Reg. Dist. No. 10

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Charles</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pisgah</i>	LENGTH OF STAY (in this place) <i>77 yrs</i>	CITY (if outside corporate limits, write RURAL and give nearest town) <i>Pisgah</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>George N. Greer</i>		<i>April 23 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>1917</i>
		9. AGE last birthday <i>77</i> yrs.	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	11. BIRTHPLACE (State or foreign country) <i>Pisgah Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>US</i>		13. FATHER'S NAME <i>Fredrick Greer</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Chumley</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Loritha Barnes Washington DC</i>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <i>Chronic Myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION	
21c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21d. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21e. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21f. HOW DID INJURY OCCUR?	
21g. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21h. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>April 20, 1957</i> to <i>April 23, 1957</i> , that I last saw the deceased alive on <i>April 20, 1957</i> , and that death occurred at <i>12:05 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Frank A. Dumas</i>		ADDRESS (Street, city, town, state) <i>Indian Head Md</i>	
DATE SIGNED <i>4-23-57</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>4/26/57</i>		NAME OF CEMETERY OR CREMATORY <i>Loritha Chapel</i>	
DATE THEREOF <i>4/26/57</i>		LOCATION (City, town, or county) (State) <i>Pisgah, Md</i>	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <i>Mary Southwick</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John Robert Johnson</i>	
DATE <i>4/24/57</i>		ADDRESS <i>4308 Greenway</i>	

**STOJILJEVIĆ**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

SEP 1 1967

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03987

3986

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> <i>Phy Mem Hosp</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Charles Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saylata md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Piuga md</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>TRAY</i> Middle <i>HENSEN</i> Last <i>HESEN</i>		4. DATE OF DEATH Month <i>4</i> Day <i>22</i> Year <i>1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Pol. cd</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 6, 1900</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>	
13. FATHER'S NAME <i>William J. Henson</i>		14. MOTHER'S MAIDEN NAME <i>Helen Dorsey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Robert Henson (Brother)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro Vascular Accident</i> DUE TO (b) <i>Hypertension</i> DUE TO (c) <i>Hypertension</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>INTERVA. BETWEEN ONSET AND DEATH</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. EDELEN</i>		DATE SIGNED <i>4-23-57</i>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/25/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Methodist Church</i>	22d. LOCATION (City, town, or county) (State) <i>Piuga md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Dne Saydalen md.</i>		24a. REC'D BY REGISTRAR <i>DATE 4/24/57</i>	24b. REGISTRAR'S SIGNATURE <i>Julia H. Poney</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 28 1957

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03988

3987

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>CHARLES</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Charles.</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural-Wayside</b>		LENGTH OF STAY (In this place) <b>Life time</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural-Wayside.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>MEL ELIZABETH JUPITER</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>April 8 1957</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>7 Feb 1882</b>	<b>9. AGE last birthday</b> <b>75</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Philip Tolson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>CARRIE WHEELER.</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>No</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Blennie Thomas - Wayside.</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <b>Respiratory Collapse</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 min</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic Cardio-cerebral-renal</b>				<b>20 yrs.</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) <b>M.</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Feb 52, to April 7, 1957, that I last saw the deceased alive on 8 April 1957, and that death occurred at 1:10 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Dr. Wooddy.</b>		<b>M. D.</b> <b>La Plata Md.</b>		<b>DATE SIGNED</b> <b>8 April 57</b>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>4-22-57</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Shilo ME Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Wayside, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE APR 25 1957</b>		<b>REGISTRAR'S SIGNATURE</b> <b>H. J. Hedrich</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The Hunt Funeral Home Waldorf, Md.</b>			

BUREAU V. S.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 415C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03989

3988 **CERTIFICATE OF DEATH**Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		STATE <u>Maryland</u>		COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>La Plata Md</u>		LENGTH OF STAY (in this place) <u>12-Hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rison</u>			
HOSPITAL OR INSTITUTION OR PHYSICIANS MEMORIAL HOSP. STREET ADDRESS <u>La Plata Md</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Dorothy Lea Murphy</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>4-26-57</u>			
<b>5. SEX</b> <u>F.</u>		<b>6. COLOR OR RACE</b> <u>W-US</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>		<b>8. DATE OF BIRTH</b> <u>10-16-56</u>	
						<b>9. AGE last birthday</b> yrs. <u>6</u> <u>10</u> <u>19</u>	
						<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>	
						<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	
						<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US.</u>	
<b>13. FATHER'S NAME</b> <u>Edward William Murphy</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Dorthea Beard</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mother-Dorthea Murphy-Rison Md</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Congenital Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6-11ths 10-Days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M. or work) (Not while at work)		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>10-16-56</u>, 19....., to <u>4-26-57</u>, 19....., that I last saw the deceased alive on <u>4-26-57</u>, and that death occurred at <u>8:30AM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James E. Andrews MD</u>				<b>DATE SIGNED</b> <u>4-26-57</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>4/28/57</u>		<u>Civil Cemetery</u>		<u>Providence Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>4/30/57</u>		<u>Julius H. Posen</u>		<u>Charles E. Rison</u>		<u>La Plata Md</u>	

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BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **100**

**3989**

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Charles</i> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sealester md</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Phy man Thurst</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Charles</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sealester</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <i>SALVATORE PAGLIARIE</i> First Middle Last <b>4. DATE OF DEATH</b> Month <i>4</i> - Day <i>23</i> Year <i>1957</i>				<b>5. SEX</b> <i>male</i> <b>6. COLOR OR RACE</b> <i>White</i> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <i>Aug 31 1905</i> <b>9. AGE</b> (In years last birthday) <i>51</i> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Post Office</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Sealester City</i> <b>11. BIRTHPLACE</b> (State or foreign country) <i>rose</i> <b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b> <i>John Pochione</i> <b>14. MOTHER'S MARDEN NAME</b> <i>Rose Bienes</i>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <i>Eugenio m Pagliaro</i> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>581.0 Hemorrhage (Esophagus)</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cirrhosis of Liver</i> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>4-23-57</i>			
PART II. OTHER SIGNIF.CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <i>19</i>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>E. J. Edelen</i> <b>EXAMINER'S NAME (Type)</b> <i>E. J. EDELEN</i>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <i>4-23-57</i>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>22b. DATE THEREOF</b> <i>4/26/57</i>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <i>Sealester Heist</i>		<b>22d. LOCATION (City, town, or county)</b> (State) <i>Sealester md</i>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Archant Inc</i> <b>ADDRESS</b> <i>Sealester md</i>				<b>24a. REC'D BY REGISTRAR</b> <i>4/24/57</i>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Julia H. Boney</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 1 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. S.

APR 23 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15MEH  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3990

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03991

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Penivy</u> First Middle Last <u>WILLIAM</u>		4. DATE OF DEATH Month <u>4</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11, 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> Hours <u>16</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Charles Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>THOMAS PENIVY</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET SAVOY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Cecelia S. Dunnington</u> Address <u>Pasadena, Md.</u>		18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONG. HEART FAILURE</u> DUE TO (b) <u>4-16-57</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. E. Edelen</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-16-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial April 23, 1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>		22d. LOCATION (City, town, or county) (State) <u>St. Charles, Charles Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson and Perkins</u> ADDRESS <u>4808 Georgia Ave.</u>		24a. REC'D BY REGISTRAR <u>5/17/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. Sullivan</u>			

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BUREAU V. S.

19 28 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

105

3991

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XU Waldorf</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES H. PROCTOR</b>				4. DATE OF DEATH Month Day Year <b>April 17, 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1898</b>		9. AGE (In years last birthday) <b>58</b> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US.</b>	
13. FATHER'S NAME <b>William E. Proctor</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Butler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>UNK.</b>		17. INFORMANT <b>Madeline Newman</b> Address <b>Waldorf, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Coronary Artery Disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-21</b> , 19 <b>57</b> , to <b>4-17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-17</b> , 19 <b>57</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Richard W. Robinson</b> M.D.				DATE SIGNED <b>APR 23 1957</b>			
PHYSICIAN'S NAME (Type) <b>Richard W. Robinson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>4-23-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or county) (State) <b>Waldorf Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Heath Funeral Home</b> ADDRESS				24a. REC'D BY REGISTRAR <b>APR 23 1957</b>		24b. REGISTRAR'S SIGNATURE <b>M. L. Mowley</b>	

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APR 23 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03993 906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bryans Road</u> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bryans Road</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Judson</u> Middle <u>Harmon</u> Last <u>Pulliam</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Richmond Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Spanish War</u>		16. SOCIAL SECURITY NO. <u>216-12-4501</u>	
17. INFORMANT <u>Gertrude L Pulliam</u> Address <u>Bryans Rd, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>4-17-57</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-22-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Funeral Home</u>		24. REGD BY REGISTRAR <u>APR 23 1957</u>	
ADDRESS <u>WALDORF, MD</u>		24b. REGISTRAR'S SIGNATURE <u>Odey Price</u>	

BUREAU V. S.

APR 23 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03994  
188

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CHARLES</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LA PLATA</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RT. #301</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pennsburg 53</u> d. STREET ADDRESS <u>101 Quakertown ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JAY</u> Middle <u>B</u> Last <u>SCHULTZ</u> <b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>14</u> Year <u>1957</u>				<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>WT</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug 26, 1933</u> <b>9. AGE</b> (In years last birthday) <u>23</u> yrs. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> IF UNDER 24 HRS.							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S.A.F</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Duquesne Pa</u> <u>uspsrt, Pa</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>					
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Libbie ?</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No, or unknown) <u>Yes</u> <u>Now</u> <u>HO 3048710</u>				<b>16. SOCIAL SECURITY NO.</b> <u>—</u>							
<b>17. INFORMANT</b> <u>Mr. Schultz</u> Address <u>101 Quakertown ave</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHED CHEST</u> DUE TO <u>BROKEN NECK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto Accident</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour <u>—</u> a. m. <u>—</u> p. m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <u>Chas.</u> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>E. J. Edele</u> <b>EXAMINER'S NAME</b> (Type) <u>E. J. EDELEN M.</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>April 17, 1957</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Duquesne</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Duquesne, Penna</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers Co., Washington, D.C.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>—</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>—</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 22 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03995

3994

Reg. Dist. No.

100

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> <span style="float: right;">Rural</span> c. LENGTH OF STAY IN 1b <u>17</u> days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9392 Old Fort Rd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Prince George</u> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> <span style="float: right;">Rural</span> d. STREET ADDRESS <u>9392 Old Fort Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>SHERMAN</u> <span style="float: right;">Middle</span> <b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>23</u> Year <u>1957</u>				<b>5. SEX</b> <u>M</u> <span style="float: right;">Negro</span> <b>6. COLOR OR RACE</b> <u>Negro</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>3-9-40</u> <b>9. AGE</b> (In years last b. day) <u>17</u> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>John S. Swann</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Pearl Proctor</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>-</u> <b>17. INFORMANT</b> Address <u>Pearl Proctor 9392 Old Fort Rd. Wash., D. C.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHED CHEST</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>TRACTOR (FIELD) TURNED OVER</u> (c) <u>4-23-57</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>4-23-57</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a. m. p. m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)				<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>E. J. EDELEN</u> <b>EXAMINER'S NAME (Type)</b> <u>E. J. EDELEN</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>4-23-57</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>4-27-57</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St Mary's Cem.</u> <b>22d. LOCATION (City, town, or county)</b> (State) <u>Piscataway, Md.</u>				<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Hunt Funeral Home Waldorf, Md.</u> <b>24a. REC'D BY REGISTRAR</b> <u>DATE 29 1957</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>J. P. P.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 27 1957

BUREAU V. S.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3996

Items 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Reg. Dist. No. 101

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rison</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rison</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>THOMAS</u> Middle <u>THOMAS</u> Last 4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1957</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1914</u> Year <u>1914</u> Month <u>1</u> Day <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHARLES</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-24-6528</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE FROM MOUTH</u> 538x DUE TO <u>UNKNOWN</u> Conditions, if any, which gave rise to immediate cause (b) <u>UNKNOWN</u> (c) <u>UNKNOWN</u> DUE TO <u>UNKNOWN</u> (a) stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C-C-N. ART SCLEROSIS</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>0</u> m <u>0</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		DATE SIGNED <u>4-7-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/10/57</u>		22b. DATE THEREOF <u>4/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Ironides, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Jenkins</u>		ADDRESS <u>480 S. Bay</u>	
24. REC'D BY REGISTRAR <u>4/8/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Southland</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

2 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be completed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03997

3996

## CERTIFICATE OF DEATH

Reg. Dist. No.

160

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Samuel Edward Thomas</b>				4. DATE OF DEATH Month Day Year <b>April 17 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12 1872</b>		9. AGE (In years, lost birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>UNK.</b>				14. MOTHER'S MAIDEN NAME <b>UNK.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James E. Thomas</b>		Address <b>Hughesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senile degenerative arteriosclerosis</b> (c) <b>Co. 2 stomach</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3-15</b> , 19 <b>57</b> , to <b>4-17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-10</b> , 19 <b>57</b> , and that death occurred at <b>4-17</b> AM, from the causes and on the date stated above.							
SIGNATURE <b>Richard H. Dobson</b> M.D.				DATE SIGNED <b>Bradyman, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Richard H. Dobson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 20, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Bryantown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home</b>				ADDRESS <b>Waldorf, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 23 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Julia C. Poye</b>			

U. S. A.

APR 23 1937

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3997 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03998

Items 8, 9 Film 6211 4-17-57 et.

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>DE.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47K-3</u> ✓	
3. NAME OF DECEASED (Type or print) <u>SYLVESTER LEON THOMAS</u> First Middle Last		d. STREET ADDRESS <u>734 Fairmont Rd NW</u>	
4. DATE OF DEATH <u>April 6 1957</u> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1898</u>
9. AGE (in years, last birthday) <u>58</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cooking</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Evelyn Smith</u> Address <u>Washington DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broken Neck</u> DUE TO <u>and/or Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>Auto Accident</u> DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4-6-57</u> <u>4-6-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>2 Car accident. Deceased occupant of rt front seat.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10:30</u> a. m. <u>4-6-1957</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 421</u>		20f. (City or town) <u>Pisgah Ches Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. Edelen M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/7/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>4</u>		22d. LOCATION (City, town, or county) <u>Washington DC</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. ...</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>4/8/57</u>		24b. REGISTRAR'S SIGNATURE <u>Juan H. Posey</u>	

RECEIVED

APR 10 1957

BUREAU V. S.

3998

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>La Plata Md.</u>		<u>12-Hours</u>		<u>XO</u> <u>Rural-Pomomkey</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hosp La Plata Md</u>				STREET ADDRESS <u>Pomomkey</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Harry Cornelias Toye</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>4-20-57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>12-31-1884</u>	
9. AGE last birthday <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>David F. Toye</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. McWilliams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-12-1652</u>		17. INFORMANT & ADDRESS <u>Bertha Brawner, deceased sister, Pomomkey, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Myocarditis, Chronic</u>						<u>Indefinite</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arterio-Sclerosis, General</u>						<u>Indefinite</u>	
DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Malnutrition due to senility</u>						<u>Indefinite</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-19-57</u> , 19....., to <u>4-20-57</u> , 19....., that I last saw the deceased alive on <u>4-20-57</u> , 19....., and that death occurred at <u>6:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James E. Andrews, MD.</u>				ADDRESS (Street, city, town, state) <u>Indian Head Md</u>		DATE SIGNED <u>4-20-57</u>	
23. BURIAL, CREMATION, RECOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-24-57</u>		NAME OF CEMETERY OR CREMATORY <u>St Charles Glymont</u>		LOCATION (City, town, or county) (State) <u>Indian Head, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Julia Rose</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>		ADDRESS <u>WALGOLF, Md.</u>	
DATE <u>4/26/57</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

399

ATTEST: REGISTERED DEATHS

DATE OF DEATH

DECEASED

AGE

SEX

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

AGE

SEX

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

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BUREAU V. S.

APR 26 1957

RECEIVED